HOSPICE REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM (CMS-417)

I. Identifying Information

Name of Hospice:

Street Address:

Request to Establish Eligibility In Medicare

Yes ☐ No ☐ **(PH1)**

City, County & State:

Zip Code:

Medicare Certification No. (CCN) **(PH2)**	**State/County** **(PH3)**	**Region/State** **(PH4)**	**Telephone Number** **(PH5)**	**Related Certification No.** **(PH6)**

II. Type of Hospice

(Check One)

- ☐ Hospital
- ☐ Skilled Nursing Facility
- ☐ Intermediate Care Facility
- ☐ Home Health Facility
- ☐ Free-standing Hospice

(PH7)

Name of Accrediting Organization:
(For Hospitals Only) *(Check One)*

- ☐ Accreditation Commission for Healthcare (ACHC)
- ☐ Community Health Accreditation Partner(CHAP)
- ☐ The Joint Commission (TJC)
- ☐ Non-Accredited

Fiscal Year Ending Date:

III. Type of Control

(Check One)

Non-Profit	Proprietary	Government	Government (cont.)
☐ 1. Church	☐ 4. Individual	☐ 8. State	☐ 12. Combination Government & Nonprofit
☐ 2. Private	☐ 5. Partnership	☐ 9. County	☐ 13. Other
☐ 3. Other	☐ 6. Corporation	☐ 10. City	
	☐ 7. Other	☐ 11. City-County	

(PH8)

IV. Services Provided:

- If by staff, place a "1" in the block(s)
- If under arrangement, place a "2" in the block(s)
- If by staff and arrangement, place a "3" in the block(s)

CORE: 1. Physician Services 2. Nursing Services 3. Medical Social Services 4. Counseling Services

5. Physical Therapy
6. Occupational Therapy
7. Speech Language Pathology
8. Hospice Aid
9. Homemaker
10. Medical Supplies
11. Short Term Inpatient Care
12. Other (Specify)

A. Acute

(PH10) B. Respite

Name & Address of Contractee:

Medical Certification / Supplier Number:

V. **Number of Employees – (Including Full-Time Volunteers**

(Top section of professional category reflects total number of FTE (i.e., PH 11 through PH 18))

Job Title		Number of Employees	Number of Full-Time Volunteers
Physicians (M.D. or D.O.	**(PH11)**		
Registered Nurses (R.N.s)	**(PH12)**		
Licenses Practical or Vocational Nurses (L.P.N or L.V.N)	**(PH13)**		
Medical Social Workers	**(PH14)**		
Homemakers	**(PH15)**		
Hospice Aides	**(PH16)**		
Counselors	**(PH17)**		
Others	**(PH18)**		
TOTAL NUMBER	**(PH19)**	0	0

Attestation Statement

Whoever knowingly or willfully makes or causes to be made a false statement or representation on this form may be prosecuted under applicable Federal or State laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the entity already participates, a termination of its agreement or contract with the State agency or the Secretary as appropriate.

Printed Name of Person Completing Form	Signature	Date Form Completed

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-0313 (Expires XX/XX/202X)**. This is a **mandatory** information collection. The time required to complete this information collection is estimated to average **45 minutes** per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

******CMS Disclosure******

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact Thomas Pryor at thomas.pryor@cms.hhs.gov.

HOSPICE REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM

(CMS-417)

INSTRUCTIONS

This form is required to obtain or retain Medicare benefits. It serves two purposes. First, it provides basic information about the Hospice which is necessary for the State to properly schedule a survey. Second, it provides a data-base necessary for responding to questions frequently asked by Congress, Federal agencies, and interested members of the public.

Submission of this form will initiate the process of obtaining a decision as to whether the Conditions are met.

Answer all questions as of the current date. Complete and return this form to your State Agency (found at https://www.cms.gov/Medicare/Provider-Enrollment-and- Certification/SurveyCertificationGenInfo/downloads/state_agency_contacts.pdf), and retain a copy for your files.

Detailed instructions are given for questions other than those considered self-explanatory.

Item I:

- Request to establish eligibility in—current Hospice Benefits are available only through the Medicare program.
- Medicare certification number:
  Insert the facility's six-digit Medicare Certification Number. Leave blank on initial requests for certification.
- State/County and State/Region Codes:
  Leave blank. The Centers for Medicare & Medicaid Services Regional Office will complete.
- Related certification number:
  If Hospice is affiliated with any other type Medicare provider, insert the related facility's six digit Medicare Certification Number.

Item IV:

- If a service is provided directly by the facility place a "1" the appropriate block.
- If a service is provided through an outside source (i.e., by contract/arrangement), place a "2" in the appropriate block.
- If a service is provided both directly and through arrangement, place a "3" in the appropriate box.